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TOP-FIVE
RECOMMENDATIONS on low-value practices

Better care. **Better** decision-making. **Better** use of resources.

The New Zealand Rheumatology Association (NZRA) is the organisation that represents the rheumatologists of New Zealand.

Their main function is to promote and maintain the standards of rheumatology practised in New Zealand. This is done in a number of ways.

1. By working with the Royal Australasian College of Physicians to oversee the training of rheumatologists.
2. By providing continuing medical education to rheumatologists in the form of the NZRA Annual Scientific Meeting.
3. By lobbying to improve the access of rheumatology patients to rheumatology services and treatments.

1. Do not perform arthroscopy with lavage and/or debridement or partial meniscectomy for patients with symptomatic osteoarthritis of the knee and/or degenerative meniscal tear

2. Do not prescribe more than the minimum effective dose of glucocorticoid (GC) therapy (10-20 mg daily) for initial treatment of polymyalgia rheumatica (PMR)

3. Do not repeat dual-energy X-ray absorptiometry (DEXA) scans for diagnosis of osteoporosis more frequently than every 5 years in patients in good health, with no risk factors for accelerated bone loss or fracture and with T scores greater than -2.00

4. Do not order extractable nuclear antibodies (ENA) testing in patients with negative antinuclear antibodies (ANA)

5. Do not order anti-double stranded (ds) DNA antibodies in antinuclear antibody (ANA) negative patients unless clinical suspicion of systemic lupus erythematosus (SLE) remains high

1 Do not perform arthroscopy with lavage and/or debridement or partial meniscectomy for patients with symptomatic osteoarthritis of the knee and/or degenerative meniscal tear

There is consistent evidence to indicate that arthroscopic lavage and/or debridement to treat people for symptomatic knee osteoarthritis, and/or partial meniscectomy for patients with a degenerative meniscal tear (with or without underlying osteoarthritis), is no more effective than placebo surgery or non-operative alternatives. The evidence for this is now so developed that a recent guideline makes a strong recommendation against knee arthroscopy in almost all patients and states that further research is unlikely to change this recommendation.

There is also a high rate of conversion from knee arthroscopy to total knee arthroplasty, which rises with increased age, further suggesting arthroscopic surgery should be avoided in people over the age of 50 years.

2 Do not prescribe more than the minimum effective dose of glucocorticoid (GC) therapy (10–20 mg daily) for initial treatment of polymyalgia rheumatica (PMR)

Only the minimum effective individualised glucocorticoid (GC) dose should be prescribed for initial treatment of polymyalgia rheumatica (PMR). The dosage should balance benefits and harms after assessing:

- risk factors for GC-related adverse events;
- comorbidities that may affect the impact of GC therapies (e.g. diabetes, osteoporosis, glaucoma, etc);
- concomitant medications; and
- the risk of relapses and/or prolonged therapy.

One recent guideline indicates a range of 12.5–25 mg prednisone (or equivalent) daily for the initial treatment, while other studies indicate that PMR remission can be achieved with prednisone treatment at a dose of 15 mg/d in most patients. Overall, we support a range of 10–20 mg daily for initial treatment of PMR with the caveat that ultimately these dosages need to be individualised for the patient.

3 Do not repeat dual-energy X-ray absorptiometry (DEXA) scans for diagnosis of osteoporosis more frequently than every 5 years in patients in good health, with no risk factors for accelerated bone loss or fracture and with T scores greater than -2.00.

There is still uncertainty over the most appropriate intervals for repeating Dual-energy X-ray Absorptiometry (DEXA) scans for monitoring bone density. Because changes in bone density over short intervals are often smaller than the measurement error of most DEXA scanners, frequent testing of less than 2 years is unnecessary in most patients. The baseline T score (which indicates osteoporosis development) is the most important determinant of a BMD testing interval. For instance, one study estimated that among older postmenopausal women with T scores above -1.50, less than 10 per cent will develop osteoporosis over a 15-year period; while among those with T scores between -1.50 and -1.99, less than 10 per cent will develop osteoporosis over a 5-year period. The equivalent periods are slightly longer for older men. Based on this and other recent evidence on cumulative incidence of osteoporosis over time, we recommend against DEXA scan monitoring more frequently than every 5 years in patients with T scores above -2.00, who are in good health and have no additional risk factors for accelerated bone loss. Risk factors for accelerated bone loss include (but are not limited to): hyperparathyroidism, aromatase inhibitor therapy, androgen deprivation therapy, steroid therapy and Vitamin D deficiency.

4 Do not order extractable nuclear antibodies (ENA) testing in patients with negative antinuclear antibodies (ANA)

Testing for antibodies to extractable nuclear antibodies (ENA) is only advised after detecting a positive antinuclear antibody (ANA) in patients with symptoms consistent with a rheumatic disease. However, in some cases ENA testing may be advisable even after a negative ANA – e.g. where there is a high pre-test probability of a rheumatic condition such as Sjogren's syndrome or where there are anti-Jo-1 antibodies for clinically suspected inflammatory myopathies.

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5

Do not order anti-double stranded (ds) DNA antibodies in antinuclear antibodies (ANA) negative patients unless clinical suspicion of systemic lupus erythematosus (SLE) remains high

International recommendations advise testing for anti-dsDNA antibodies only after detecting a positive antinuclear antibody (ANA) in patients with symptoms consistent with systemic lupus erythematosus. In patients who are ANA negative, anti-dsDNA should only be ordered in clinical situations where the pre-test probability of SLE is high.

For the list of references supporting these recommendations and further information on the development process, see **evolve.edu.au/published-lists/new-zealand-rheumatology-association/**

WHAT IS EVOLVE?

Part of a global movement, Evolve is an initiative led by the Royal Australasian College of Physicians (RACP) to drive high-value, high-quality care in Australia and New Zealand.

As medical practice and medical research continues to grow in volume and complexity, physicians can be inundated with new guidelines, new research and new information. Evolve helps physicians to stay abreast of the current evidence and recommended best practice to support the provision of high-value, high-quality care to patients.

How does Evolve work?

Evolve identifies a specialty's Top 5 clinical practices that, in particular circumstances, may be overused, provide little or no benefit, or cause unnecessary harm.

Evolve recommendations are developed through a rigorous, peer-reviewed process; led by clinical experts, informed by in-depth evidence reviews, and guided by widespread consultation.

Evolve contribution to the Choosing Wisely campaigns

RACP is a founding member of Choosing Wisely in Australia and New Zealand, and all Evolve recommendations are also available via these campaigns.

By bringing together recommendations from multiple medical colleges and healthcare organisations, together with expertise in consumer and patient care, Choosing Wisely helps healthcare providers and consumers start important conversations about improving the quality of healthcare.